Life Safety Consortium, LLC

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Sparks of Interest

Inside this issue

COVID Surge

In the Midst of Another Surge

Rhode Island's hospitals reached their COVID-19 capacity on November 30th the state said in a statewide emergency alert. Over the past two weeks the highest growth rate of COVID-19 cases, according to Johns Hopkins University, has been in New Mexico, Arizona, Virginia, California, and Louisiana. Clearly, we are in the midst of another COVID-19 surge. But it is different this time. Last Spring, we witnessed cases in the Northwest, California, New York, and New England. As the number of new cases decreased in those areas, we witnessed increases in the Southeast and then in the Southwest. This time we are seeing a significant increase in cases in over 40 states, all at the same time.

What Can Facilities Do?

In Rhode Island, and other states, we are seeing alternate care sites and field hospitals being established or re-opened. Health care organizations need to review their emergency preparedness plans, incorporate lessons learned from the previous surge, and begin the planning process for providing patient care in alternate sites. This should not be limited to completely separate locations but should also include repurposing areas in the hospital to provide in-patient care. The Facilities Guidelines Institute (FGI) is preparing an Emergency Conditions White Paper and while the paper is in its final stages of development, it is not yet ready to be released. Other resources that were available last Spring, such as the US Army Corps of Engineers website, NFPA, and Accrediting Organizations, continue to make their resources available to help with the planning process.

One of the challenges this time will be staffing of the alternate care sites. During the surge last Spring, care givers in those areas not impacted relocated to areas where additional resources were needed. Cleveland Clinic recently announced that nearly 1,000 health care workers were unable to work because of a COVID diagnosis or the need to quarantine. With a decreasing number of care providers and the widespread nature of the current surge, certain types of alternate care sites may be more desirable. Although not many were actually put to use, last Spring hotels were considered a viable option to serve as alternate care sites. However, large open span structures (convention centers, arenas, hotel ballrooms, school gymnasiums) may be better suited from a staffing perspective since the areas can be more easily reconfigured into a "suite" type arrangement, potentially reducing the number of staff needed to provide care as compared to a small room arrangement of a hotel sleeping floor.

With respect to providing care in alternate settings, it would be appropriate to begin the dialogue now with your respective authorities having jurisdiction. They too will be better prepared and informed to assist based upon lessons learned earlier this year.

Continued on the next page.....

Special point of interest

The Association for the Healthcare Environment (AHE) has released several COVID-19 resources for environmental services professionals. Some of the free resources found on the COVID-19 Resources for EVS Professionals 2020 webpage include:

- An infographic on COVID-19 environmental services considerations
- A video on the chain of infection

View the AHE resource page.

Author

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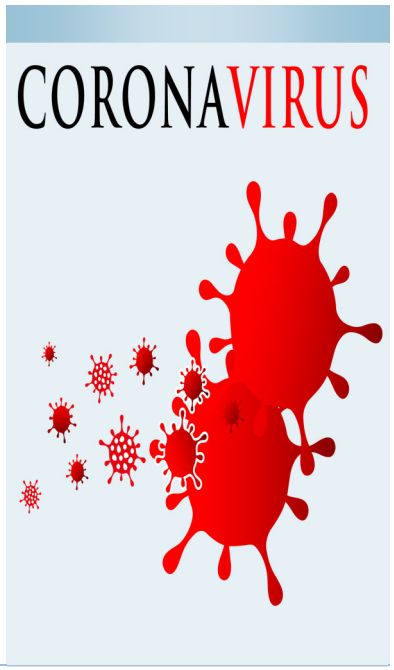
COVID Surge Continued….

Inspection, Testing, and Maintenance

The ability to continue required inspection, testing, and maintenance activities were adversely impacted during the past surge. Some State Agencies prohibited access to health care facilities by contractors who were not directly related to the delivery of medical care. Some contractors were hesitant to send personnel into health care facilities providing care for COVID-19 patients. Facility personnel were already overwhelmed with making changes to accommodate the increased demand for patient care to the extent that they were not available to perform ITM activities. All of this led to CMS issuing a Section 1135 waiver permitting the delay in performing certain, but not all, ITM activities. If a facility is not already experiencing a surge and especially if they are within the timeframe that ITM activities need to be and can be performed to meet the required frequency, it may be beneficial to consider having those activities performed, especially the ones not impacted by the Section 1135 waiver.

Surveys

As of the time this article is being written, there have been no announcements from CMS or the Accrediting Organizations that surveys will be discontinued. Even if surveys are discontinued in the future, facilities are still required to meet state licensure requirements and the CMS Conditions of Participation (COP), unless CMS has or does issue a Section 1135 waiver impacting

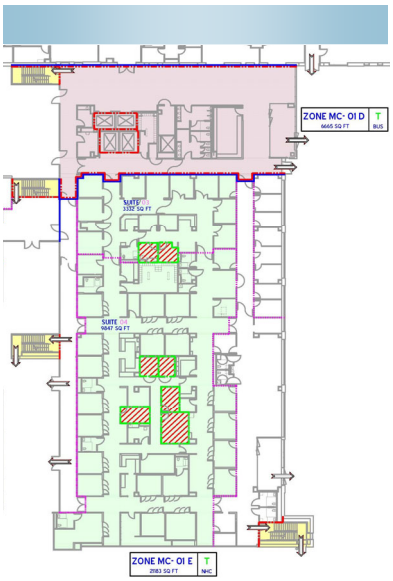


"With respect to providing care in alternate settings, it would be appropriate to begin the dialogue now with your respective authorities having jurisdiction. "

a particular COP. Consistent with the recommendation above regarding ITM activities, where possible the required assessments and walk-throughs should be performed prior to experiencing a surge.

Summary

Unfortunately, it appears that the health care industry is in for another period of increased demand for patient care. COVID-19 is a contributing factor, but not the only factor since we are also in peak flu season in the USA. Health care organizations will need to implement the lessons learned from the past COVID-19 related surge as well as consider factors that may make this surge different. Overall, the health care organizations handled the last surge well and with proper planning should also handle this new surge well.



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WOSB & MBE Pending

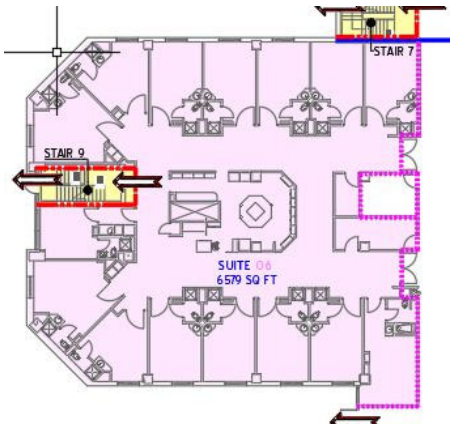
Suites

A suite - what is it? Think of it as one big room with a envelope wall boundary which encompasses multiple rooms within it. There are many reasons why implementing suites in a health care facility is so beneficial. It is as simple as understanding the requirements for suites. With the proper application, benefits can include a reduction in requirements for corridor storage and door hardware which can be a major benefit to your facility while helping your maintenance budget.

There are other nuances for applying suites under the 2012 Edition of the Life Safety Code®. Here's a general overview:

All suites:

- Travel distance from any point to an exit access door is limited to 100 ft.
- Travel distance from any point to an exit is limited to 200 ft.
- Second means of egress can be through adjoining suites.
- A Suite cannot create a dead-end corridor in excess of 30 ft.
- Be careful of land locking a suite (meaning not having an exit to a corridor).



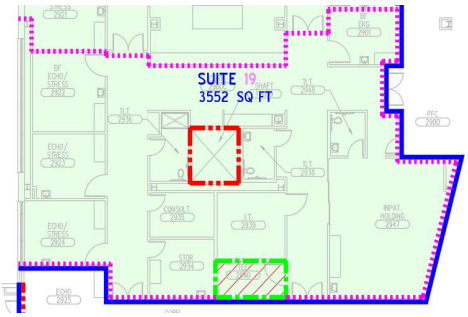
Example of a Sleeping Suite

Patient Sleeping Suites (ICU, NICU, CCU, some general nursing units if properly designed):

- Limited to 5,000 sq. ft.
- Or up to 7,500 sq. ft. if sprinkler protected, and complete smoke detection OR direct supervision.
- Or up to 10,000 sq. ft. if sprinkler protected, complete smoke detection AND direct supervision.
- 2 means of egress if more than 1,000 sq. ft.

Patient Non-Sleeping Suites (ED, OR):

- Limited to 10,000 sq. ft.
- 2 means of egress if more than 2,500 sq. ft.

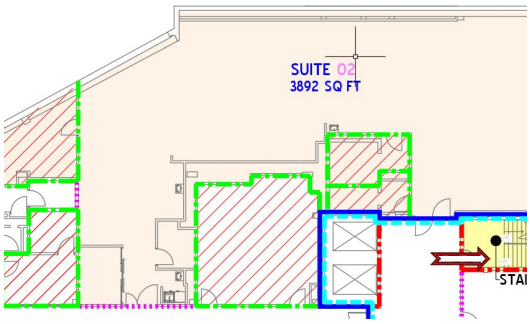


Example of a Non-Sleeping Suite

Non-Patient Care Suites (Labs, Pharmacy):

- Egress requirement is in accordance to primary use and occupancy

Having a knowledgeable third party review your life safety drawings will ensure your facility is taking advantage of the benefits that using suites can give your facility. It will also ensure that suites are being applied properly and within the allowable codes. Therefore, avoiding any issues with AHJ'S, inspectors or other officials that can arise when suites are not applied efficiently or correctly.



Example of a Non-Patient Care Suites

Being Proactive

Going Proactive

Author

Ken Mustafa—Risk Management Specialist with 20 years experience in Healthcare Consulting and Mechanical Contracting

It wasn't so long ago that we were in a similar, difficult predicament in healthcare. During the Great Recession, patient census dropped, elective procedures were postponed, and hospital cash flow was underwater. As a result, capital plans were deferred, budgets slashed, preventative maintenance shelved, and staff cut.

As it was then, it is now for a very different reason. Today, we're in the throes of a pandemic in which we haven't hit bottom. We see the same disastrous issues: low census, postponed elective procedures, significantly reduced cash flow, all causing deferred capital spending, budget and staff reductions, and ignored preventative maintenance. However, there is light at the end of the tunnel. Our understanding of the virus, including prevention and treatment, is improving daily. And the genuine promise of effective vaccines is on the horizon.

Just like the Great Recession, an incredible amount of pent-up demand is building up. As soon as we get meaningful control of the virus, we will see the economy boom – healthcare will lead that boom. We'll see major M&A activity. And we're going to see census numbers climb as elective procedures spike. We need to make sure we can earn the trust of the public by investing in the safety and quality of our facilities.

"Today, we're in the throes of a pandemic in which we haven't hit bottom."

We need to be ready – which presents many challenges:

- Healthcare workers are already drained from battling the pandemic
- There will be intense competition among hospitals for those seeking elective procedures
- This has been a highly reactive time to facility challenges, so we need to transition to a proactive mindset to get ahead of the demand curve

The time is right for addressing issues sooner rather than later:

1. Life Safety Assessments and Mock Surveys – are you ready for an AHJ survey? What impact will a negative survey have on your hospital's reputation?
2. Infection Prevention – are your IP practices going to build trust with patients?
3. Water Management – are you protecting your patient populations from waterborne pathogens? Now is not the time to have Legionella issues.
4. Capital Planning – do you have a decision support framework to guide spending of precious resources?

As we come out of the pandemic, we only have one shot at a first impression. Will it be of a safe, issue free environment? Or will it be of regulatory issues and preventable hospital acquired infections?

Effective Point of Interest

Effective Jan. 1, 2021: Revision to LS.02.01.35, EP 7 - Effective Jan. 1, 2021, The Joint Commission has revised its Life Safety (LS) Standard LS.02.01.35, element of performance (EP) 7 for hospitals, critical access hospitals and behavioral health care organizations.

The change was made to address the National Fire Protection Association (NFPA) requirement that spare sprinkler heads of each type installed in the organization need to be available.

The LS.02.01.35 standard requires that organizations provide and maintain systems for extinguishing fires, while EP 7 requires that at least six spare sprinkler heads of each type and temperature rating installed in the facility are readily available along with the associated wrench or tool to replace the sprinkler head. The spare sprinkler heads and wrench or tool are stored in a cabinet location that does not exceed 100 degrees Fahrenheit.

This change can be found in the current Jan. 1, 2021, version of the E-edition and the 2021 hard copies of the accreditation manuals.

Fire Doors

Principles of Performing Door Safety Inspections (Part 1)

Notice: The comments and opinions expressed in this article are based solely on the author's expertise and experience. They do not represent the official positions or opinions of the NFPA, ASHE, or any other organization.

Much has been written and said about performing NFPA 80's door safety inspection and testing requirements since they first appeared in the 2007 edition. And yet, as 2020 is winding down, confusion about conducting these door safety inspections seems to be rampant. Many of the persons performing this work don't know how to apply NFPA 80's inspection and testing criteria correctly; especially, as it pertains to older existing door assemblies. Most AHJs don't know how to apply all of NFPA 80's requirements to older existing fire doors, which further complicates enforcement of these requirements.

Consequently, facility managers sort through massive door inspection reports to separate the necessary repair work they have to complete from the erroneously-listed repair work cited by ill-trained and ill-prepared inspector personnel. In many cases, facility managers have to decide between trusting the accuracy and completeness of the inspection reports—by making all of the repairs listed—and culling-out the necessary repairs from the incorrectly cited deficiencies recorded in the inspection reports.

The first principle of performing NFPA 80's door safety inspections and testing—that everyone involved needs to know—is that the door assemblies should be inspected in accordance with the codes and standards that were in effect at the time of installation. This overarching principle first appeared in the 1981 edition of NFPA 80, and it is still in NFPA 80 today—see paragraph A.1.3 in NFPA 80—as it has been in every edition since then.

An important concept to bear in mind regarding older existing fire doors is that there is no expiration date on these components and systems. Owners and facility managers are not required to upgrade their fire doors as code and standard requirements evolve. For example, labels on frames and doors installed in the 1940s, 1950s, and 1960s (and so on) don't look the same as today's labels, just as today's fire door labels won't look the same as labels twenty-five years from now.

Understanding when and how to apply this first principle of NFPA 80's door safety inspections and testing is crucial to correctly maintaining fire doors in working condition—that is to say, keeping them in a constant state of readiness.

NFPA 80 is a mature standard; its origin dates back to 1897. Following are a few examples of when the first principle of these inspections and testing should be applied to older existing fire door assemblies:

- Wire Glass—For over a century, wire glass has been used in fire door assemblies. In fact, wire glass is still permitted to be used in new fire doors assemblies, albeit today's codes restrict its use to small sections (e.g., 10 in. x 10 in. vision panels and narrow lights in door leaves) and locations not subject to human impact (e.g., in transom lights of door frames). For most of the first one-hundred years, marking of wire glass was not required.

- The 1992 edition of NFPA 80 was the first edition to require individual sections of wire glass to be marked. At that point in time, the markings on wire glass were unregulated by the codes and could be as simple as the ubiquitous UL symbol. It wasn't until the adoption and enforcement of the IBC in the early 2000s that markings on glass and glazing materials in fire door assemblies required specific information and coding marked on each piece (e.g., D-H-T-90, D-H-180, etc.). Therefore, when the installation of fire door assemblies predate the adoption and enforcement of a code or standard that requires markings on glass and glazing materials, the absence of those markings is not a deficiency.

- Further complicating the issue, today, some jurisdictions allow wire glass—unmarked and marked—to be used, even though the prevailing codes don't. For this reason, the appropriate AHJs need to be consulted to determine when wire glass is allowed in their jurisdictions, marked and un-marked.

- Labels—Hourly fire protection ratings were not (and are not today) required to be printed on labels attached to certain types of door frames (e.g., 16 and 14 gauge hollow metal frames). Nor are the hourly fire protection ratings of the door frames and doors required to match. Many labels from the 1940s and 1950s did not include information for latching hardware

- Signage—Before the 1995 edition of NFPA 80, signage was not covered in the standard. In other words, signage applied to fire doors was unrestricted.

Continued on the next page….

Author

Keith E. Pardoe's career in the swinging door industry spans more than thirty-five (35) years. For more than 18 years, he was the Director of Education and Certification for the Door and Hardware Institute (DHI). His professional certifications include Fire Door Assembly Inspector (FDAI), Distinguished Architectural Hardware Consultant (DAHC), and Certified Door Consultant (CDC). Currently, he serves as a volunteer instructor for DHI Canada, and he is a member of ASHE's Faculty team. He is also a longtime volunteer for NFPA, where he serves now as the Chair of the Fire Doors and Windows Technical Committee.

Got questions? Need more information? You can reach Keith by email at kpardoe@DoorSafety.com and through LinkedIn.

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Fire Doors Continued….

Principles of Performing Door Safety Inspections (Part 1)

- Protection Plates—The first mention of using protection plates on fire doors in NFPA 80 occurred in the 1973 edition; it merely mentioned the materials—size and placement were not restricted. Later, the height of the kick plates was limited to twelve inches in the 1974 edition of NFPA 80 and increased to sixteen inches in the 1981 edition. However, it's important to know is that there was an exception to the size and placement limitations that allowed for larger sizes and placements of protection plates provided they were "…otherwise tested and approved." In the context of NFPA 80, "tested" meant by the respective manufacturers, and "approved" meant accepted by the AHJ. To be clear, protection plates were not required to be labeled or marked in any manner until the 1999 edition of NFPA 80. Said another way, protection plates installed on fire doors were not required to be labeled for about the first one-hundred years.

These are only a few examples of how NFPA 80's requirements have changed over the years; there are several more about which we could talk. None of these items are deficiencies on older existing fire doors since the codes and standards at the time of installation did not cover them. However, the ill-trained inspectors ignorantly attempt to apply NFPA 80's current requirements to older existing fire doors. For instance, they mistakenly insist that unmarked wire glass in older existing doors needs to be replaced with new glass and glazing materials, or they recommend the facility hire a company to mark the glass. Some of these ill-trained inspectors recommend the facilities hire a company to apply new labels to door frames and doors so that the hourly fire protection ratings match; that, too, is unnecessary.

"Consequently, facility managers sort through massive door inspection reports to separate the necessary repair work they have to complete from the erroneously-listed repair work cited by ill-trained and ill-prepared inspector personnel. "

Similarly, the ill-trained inspectors insist on removing or replacing non-labeled protection plates or recommend the facilities hire a company to apply labels to the existing protection plates. It's important to know that there is no basis in the codes or standards that support any of these findings when the installation of the affected doors predates the introduction of these (and other) requirements into the codes and standards; none.

The result, of course, confuses and frustrates facility managers, causing fire doors to be upgraded unnecessarily, costing facilities many thousands of dollars that could have been used for other important purposes.

Summary

Everyone involved in the installation, inspection, testing, and maintenance of fire door assemblies need to take the time to study the history of door assemblies with which they are concerned. For example, knowing the approximate installation dates identifies which era of codes and standards apply to specific doors. In other words, some of today's codes and standards requirements do not apply to fire door assemblies that were installed before the current codes were adopted.

Facility managers and owner personnel need to be able to sort through all of the noise created by the inspection reports created by ill-trained and ill-prepared inspectors. Before hiring a company to perform NFPA 80's door safety inspections, interview the prospective inspection-service companies to determine how they apply the inspection criteria to older existing door assemblies. Ask pointed questions that cover topics such as those discussed in this article. Take the time to research the inspectors' certifications and credentials; don't accept them on their face value.

FROM ALL OF US: stay safe and take care.

Huge thanks to the Healthcare Workers on the front line of the coronavirus pandemic